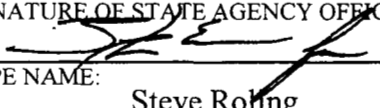
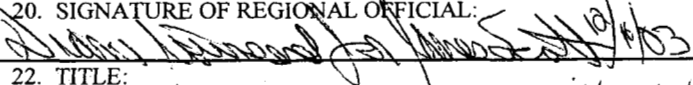


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION		1. TRANSMITTAL NUMBER: <u>0 3 --- 1 5</u>	2. STATE MO
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE 10/16/2003	
5. TYPE OF PLAN MATERIAL (Check One): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR.440.210		7. FEDERAL BUDGET IMPACT: a. FFY <u>04</u> \$ <u>0</u> b. FFY <u>05</u> \$ <u>0</u>	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Section 3.1A, Page 14a		9. PAGE NUMBER OF THE SUPERSEDES PLAN SECTION OR ATTACHMENT (If Applicable): Section 3.1-a, Page 14a	
10. SUBJECT OF AMENDMENT: A change in the global prenatal benefit for prenatal visits from five visits to four, in order to conform with the specifications of Current Procedural Terminology (CPT) coding.			
11. GOVERNOR'S REVIEW (Check One) <input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <i>See</i> <input type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: Department of Social Services Division of Medical Services 615 Howerton Court P.O. Box 6500 Jefferson City, MO 65109	
13. TYPE NAME: Steve Rohing			
14. TITLE: Director			
15. DATE SUBMITTED: September 25, 2003			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: September 26, 2003		18. DATE APPROVED: NOV 18 2003	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: OCT 16 2003		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Thomas W. Lenz		22. TITLE: ARA for Divct Medicaid & Children's Health	
23. REMARKS:			

State Missouri

- (2) The physician or optometrist actually performing, or exercising a direct personal supervision of the performance of the service, is participating in the Physician or Optical Care Program and is identified on each line item of service representing a professional service for which they are responsible by their provider identification number. (This item applies to all clinic provider types except Public Health Department Clinics, those Independent Clinics having an Ambulatory Surgical Care Type of Service designation and Adult Day Health Care centers.)

Clinic services are payable in accordance with all guidelines, restrictions, and limitation of Physicians' Services for all the clinic provider types except Professional Clinic Optometry which is the same as Optometrists Services, those Independent Clinics having an Ambulatory Surgical Care Type of Service designation and Adult Day Health Care Centers. Ambulatory Surgical Care covered services are those specifically listed surgical procedures and related ancillaries which are provided in accordance with A.S.C. guidelines. Obstetrical delivery services are not included. Prior Authorization is required for the surgical procedures of Blepharoplasty and Excision of Keloids when performed in an Ambulatory Surgical Care Clinic. Adult Day Health Care services are provided in accordance with State Regulation 13 CSR 70-92.010 and subject to limitations as specified therein.

The global prenatal benefit covers all prenatal visits, routine urinalysis testing and pregnancy related conditions during the recipient's pregnancy period. Coverage of this benefit requires a minimum of four prenatal visits be provided and will be limited to one global service per pregnancy.

Coverage for clinical services related to the performance of certain specified elective surgical procedures requires the recipient obtain a documented medical second opinion. Coverage is provided for a documented third opinion, at the recipient's choice, when the second opinion fails to confirm the surgery recommendation of the first opinion.

Bone marrow, heart, kidney, liver, lung and certain restricted multiple organ transplants and related transplantation services are covered when prior authorized. Corneal transplants are covered without a requirement of prior authorization.

State Plan TN# 03-15
Supersedes TN# 93-41

Effective Date December 15, 2003
Approval Date NOV 18 2003